An Information Environment For The Millennium: The Ontario Family and General Practice Data Standards Project

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Clinical records in family and general practice have as a first purpose that of documenting and supporting the process of continuing and comprehensive care to which the family/general practitioner is dedicated. Clinical records are the basis for practice, and are the underpinning for all phases of care. The development of the computerized office has highlighted the need for universally-accepted standards for information that will make information shareable and enhance care itself.

The Data Standards Program addresses the identification of the constituencies that depend on the clinical record, the definition of their dependencies in terms of the uses they have for data and the access they require, and the identification of the critical types of and, wherever possible, the specific data they need to perform their authorized roles. The program targets the widespread adoption of the standard record, and its continuous adaptation so as to retain relevancy in the future.

During 1992, the Project Steering Committee completed the first phase of the Program (the Data Standards Report). The goals of this phase have been met, and the report has been released for production.

DATA STANDARDS PROJECT DELIVERABLES

The major deliverables of the Data Standards Project (embodied in the project report) are:

1. The Care Management Process Model (CMPM)

The Care Management Process Model is a comprehensive descriptive model of the care management process that defines all phases of care, the types of activities that occur during each phase, the uses made of data during each activity performed, the data required to support these uses, the data evolved during each activity, and the required documentation of the care process.

2. The Care Data Model (CDM)

The Care Data Model documents the data needed and produced during the Care Management Process. The CDM defines a Data Dictionary, the data element aggregates (subject databases) and the constituents' views (e.g., Problem orientation) that will support their usage, and the selections and combinations (views) that address the needs of various user-types.

Associated with the CDM is a set of guidelines and methods to select an operant clinical vocabulary and required classification systems.

3. The Care Support Records Process (CSRP)

The Care Support Records Process is the record capture, storage, organization, retrieval and presentation mechanism that supports the Care Management Process. It includes manual approaches.

4. The Records Process Interfaces (RPIs)

The Records Process Interfaces are the pathways by which data flows to and from various user-types.

5. Records Process Guidelines (RPGs)

The Records Process Guidelines are statements of characteristics of the following:

- The tools and implementation methods that are required to deliver the records management process in each of three settings: a manual setting, a low-tech setting that assists but does not fully computerize the record, and a fully electronic medical records system;
- The means of achieving the wide-spread adoption of the CSRP;
- The approach that will carry the CSRP to completion and allow it to evolve to meet future demands.

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